CHCS Center for Health Care Strategies, Inc.

Initial Considerations to Guide the Development of Medicaid Health Homes

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The Affordable Care Act of 2010 (ACA) presents a new opportunity for Medicaid programs to develop health homes for patients with multiple chronic conditions and/or severe mental illness. Through health homes, Medicaid can reimburse for critical services: comprehensive care management; care coordination and health promotion; transitional care; individual and family support; and referrals to community and social support services. States will be eligible to receive 90/10 federal matching funds for two years, thus creating a tremendous opportunity to demonstrate how coordinated care management can improve quality and potentially bend cost trends.

To begin to explore how states can develop health homes, the Center for Health Care Strategies (CHCS) convened a group of Medicaid officials from Maine, New Mexico, Ohio, Oregon, and Washington; representatives from the Robert Wood Johnson Foundation's *Aligning Forces for Quality* regional quality alliances; officials from the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration; and other national experts. Through the ensuing discussion, six key considerations emerged to help guide states in the preliminary planning and development of health home programs. This technical assistance document outlines these initial considerations and provides a starting point to help states with health home program design.

IN BRIEF

The Affordable Care Act includes several opportunities to support Medicaid in transforming the health care delivery system, including Section 2703 promoting health homes for enrollees with chronic conditions. This document outlines initial considerations to help states in the preliminary planning and development of health home models. A hands-on checklist walks states through a list of decision points to guide the design of health home programs.

1. Leverage existing resources.

States interested in health homes should leverage the capacity of the local health care infrastructure and programs currently in place. In particular, states can explore how to enhance or expand upon existing care management programs that currently deliver a portion of health home services. By layering health home services onto established programs and building new capacity as needed, states can make the most of existing capacity and deploy scarce Medicaid resources efficiently. By building on programs that providers already utilize, states can make health home participation more attractive to a wider set of providers.

2. Build in flexibility.

Health home program design needs to be flexible to take advantage of the variation among health home providers, beneficiaries, and health system infrastructures and the unique needs of different patient subpopulations. Allowing some degree of variation in care delivery processes, staff roles, and integrated models for behavioral health and long-term care services will help states in meeting the needs of different sub-populations. Giving providers the flexibility to determine the optimal approach for their organizations, while

holding them accountable for successfully delivering health home services, will contribute to program effectiveness.

Patient needs will vary by their physical and behavioral health conditions, the severity of those conditions, their access to social supports and housing, and other factors. Considerable variation will exist both within a single provider's patient panel and across providers. Ideally, providers should have the flexibility to adapt the delivery of health home services and the intensity of the services to meet beneficiaries' needs.

States will need to strike a balance between providing sufficient specificity in the program requirements and granting providers the flexibility to deliver health services in a way that best meets patient needs. For example, states will need to provide service definitions in their State Plan Amendment (SPA) that clearly articulate the key components providers will be required to deliver as part of the six health home services. States can give flexibility by remaining silent on how providers meet those requirements or deliver those defined services.

3. Ensure accountability.

All entities providing health home services, whether a designated provider, multi-disciplinary team, or other entity, must be held accountable for delivering the health home services, providing accurate program data, achieving improved outcomes, and potentially, reducing costs.

Accountability requires a clear set of performance standards and a process to assess compliance. As discussed above, establishing provider eligibility guidelines and service definitions can foster accountability at the provider level. As part of the health homes SPA, CMS requires states to collect quality, utilization, efficiency, and patient experience measures. States can hold providers accountable by: 1) identifying outcomes of importance to specific populations and regions; 2) developing measures to accurately capture those outcomes; and 3) establishing regular reporting mechanisms. Medicaid can also embed requirements within their contracts with providers and health plans, which are a powerful lever for accountability.

Providers will enter the program at different levels of readiness and capacity. Therefore, states should consider ramping up performance standards over time to reflect and stimulate performance improvement. States may also consider making technical assistance available to providers who need training and help building health home service delivery mechanisms and infrastructure.

4. Align financial incentives.

Health homes provide a mechanism for Medicaid to reimburse providers for six new care management activities that were previously unbillable. States should not only reimburse providers for delivery of health home services, but also for the resources to provide those services and achieving program objectives. Without appropriate financial incentives, states will retain a payment structure that does not sufficiently incent the effective delivery of these services, and the program will have a limited impact, at best.

Reimbursement strategies should build upon methods that promote accountability and flexibility and reflect the capacity of providers to meet certain goals. States may reimburse for health home services directly through per member per month reimbursement. States can directly invest in resources such as care managers and practice coaches or they may simply provide funding for providers to use as they see fit for these services. Medicaid may also want to pay providers for achieving specific outcomes, such as lower HbA1C levels or reduced visits to the emergency room. For example, states may consider using a shared savings model as an incentive for providers to reduce unnecessary emergency room utilization and costs. However, this outcome-based approach may not be effective if providers do not yet have the capacity to achieve the desired outcomes. Instead, states can initially consider performance-based payments that focus on process measures, and gradually phase in outcome-based payments. Under either approach, states can seek to align providers' financial interests with performance standards, while giving them flexibility in delivering health home services to meet those goals.

Under a health home reimbursement model, the fundamentals of sound payment policy still apply: 1) providers should be clear on what services are generating revenue; 2) providers should understand the amount of revenue they will receive in return; and 3) processing payments should be administratively easy for both providers and Medicaid.

5. Foster transparency and stakeholder engagement.

Beneficiaries, providers, and other stakeholders should be well-informed about the health home program. This includes clarifying what is required of them as well as the benefits of being part of a health home. Helping eligible individuals understand the services available to them, the benefit of tapping into the services, how to access those services, and which providers are participating will increase patient engagement and contribute to program success.

Setting program goals and holding providers accountable will only be effective if individual providers, not just their organizations, understand the program requirements, goals, and the associated financial rewards. States should include other providers such as specialists and hospitals, with whom the health home providers will be coordinating care. Keeping other interested stakeholders such as health plans and regional initiatives informed of the health home program will foster their engagement and support as well.

In light of existing time demands and the myriad of quality improvement programs already in place in many states, attracting the level of stakeholder attention necessary will be difficult. Program communications that go beyond press releases and informational letters can be expensive and time-consuming. Yet effectively educating beneficiaries and providers early in the process will help states enroll participants quickly and maximize the enhanced federal funding.

6. Focus on sustainability.

By considering sustainability issues at the onset of the program design process, states can better leverage the enhanced match to make the business case for investing in the health home program over the long term.

States may consider several approaches to build sustainability:

- Under current CMS guidance, states may phase in the health home program gradually, receiving eight quarters of enhanced federal funding for each phase of program roll-out. Phasing enables states to incorporate lessons from early program implementation, making subsequent iterations more successful.
- Focusing on beneficiaries for whom there may be the greatest opportunity to improve outcomes and reduce costs may enable states to make the business case to add additional populations or to sustain the service once regular federal matching rates apply.
- Incorporating health homes into similar multi-payer efforts may enable states to leverage shared infrastructure, build on existing provider efforts, and use resources more efficiently, thus reducing costs. Provider participation is also more likely to increase if the health home program aligns with similar efforts undertaken by other purchasers.
- Demonstrating a return on investment (ROI) will help position states to request additional funds from policymakers, who are more likely to be interested in sustaining health home programs when costs are offset by corresponding health care savings.

Conclusion

Every state Medicaid program is different. Depending on program details, some of these considerations may be more important from a program design perspective than others. This framework can serve as a starting point for program planning. States can also use it to evaluate and prioritize existing programs that can serve as building blocks to health homes.

In particular, states can consider how a health home program will support their long-term vision for improving health care delivery. Health homes can serve as a foundation to build more advanced systems of care, such as accountable care organizations, and to adopt more sophisticated payment methods, like episode-of-care or bundled payments. Acknowledging these long-term goals can help state planners design a health home program that provides an effective transition to more advanced models of care. *(See the checklist on pages 5-6 for a hands-on tool to guide in program planning.)*

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs.

Future CHCS resources will provide additional direction to guide states in establishing health home approaches. Visit **www.chcs.org** for a growing library of resources designed to help Medicaid stakeholders develop innovative health home models, including:

- *ROI Forecasting Calculator for Health Homes and Medical Homes*
- *Fact Sheet: Health Home Opportunities for Medicaid*
- *Medicaid Health Home Program Design Strategies: Summaries of State Exchange Sessions*

STATE CHECKLIST: Applying Health Home Principles to Program Design		
Guiding Principle	**Why Important**	**Potential Program Design Approaches**
1) Leverage existing resources	Enables states to make the most of existing capacity and deploy scarce Medicaid resources efficiently	▪ Use patient-centered medical home programs as a foundation for health homes. ▪ Build upon existing complex care management initiatives for high-need, high-cost beneficiaries. ▪ Incorporate existing care management and supportive services in the behavioral health delivery system (e.g., through community mental health centers, community-based organizations, or supportive housing programs, etc.). ▪ Tap into practice-level investments in health information technology (HIT) to facilitate the information exchanges and performance measurement critical to a health home program. ▪ Incorporate long-term care programs and managed care infrastructure. ▪ Include physical and behavioral managed care organizations as members of the health home team.
2) Build in flexibility	Takes advantage of the variation among health home providers, beneficiaries, and health system infrastructures; fosters innovations in care	▪ Define a minimum set of health home service requirements (e.g., health assessments, the development of self-management plans), but allow providers to determine and define how they will meet those requirements. ▪ Provide an initial set of provider qualifications, but give providers flexibility to assemble their health home team among a wide variety of qualified provider types. ▪ Allow providers to utilize program supports (e.g., care managers, practice coaches) to the degree and at the level of intensity they deem appropriate.
3) Ensure accountability	Aligns provider interests with the achievement of health home goals: improving health outcomes and reducing health care costs	▪ Identify processes and outcomes of importance to specific populations and regions. ▪ Identify measures to accurately and easily capture those processes and outcomes. ▪ Establish standardized reporting mechanisms. ▪ Make results transparent to patients and other health home providers. ▪ Tie payment to the achievement of outcomes. ▪ Align health home requirements in managed care and provider contracts. ▪ Provide technical assistance to help providers meet program requirements and improve.

STATE CHECKLIST: Applying Health Home Principles to Program Design		
Guiding Principle	**Why Important**	**Potential Program Design Approaches**
4) Align financial incentives	Incents providers to make the necessary investments and provide high-quality health home services	▪ Contribute a per member per month (PMPM) payment for care management and coordination services. ▪ Tier PMPM payments and make more money available to providers who achieve specific outcomes, such as lower HbA1C levels. ▪ Use a shared savings model as an incentive to reduce unnecessary emergency room and readmission costs. ▪ Incentivize providers to reinvest health home payments in areas that will best support their patients.
5) Foster transparency and stakeholder engagement	Increases patient enrollment and provider engagement	▪ Create friendly, plain-speak materials to help patients understand the services available to them, the benefits of the services, how to access those services, and which providers are participating. ▪ Create incentives for patients to participate in health homes. ▪ Use multiple vehicles (e.g., webinars, letters, in-person sessions) to deliver information to health home providers about the program. ▪ Communicate to providers, such as specialists and hospitals, with whom the health home providers will be coordinating care. ▪ Link providers to key community supports. ▪ Establish peer-to-peer learning networks for health home providers.
6) Focus on sustainability	Enables states to better leverage the enhanced match to support the health home program over the long term	▪ Begin with a program size that is feasible to implement and later expand the program size by geography, new patient populations, or both. ▪ Focus on high-need, high-cost beneficiaries, for whom there may be the greatest opportunity to improve outcomes and reduce costs. ▪ Incorporate health homes into multi-payer medical home efforts, which may enable states to leverage shared infrastructures, build on existing provider efforts, and use resources more efficiently. ▪ Demonstrate a return on investment (ROI) to make the case for investments in health home programs.